



ASTHMA HEALTH CARE PLAN

School _____ Fax Number _____ Effective Dates _____

Student's Name: _____

Date of Birth: _____

School/Grade: _____ **Age when asthma diagnosed:** _____ **List all routine daily medications (name of medication, dose, and times given):**

SYMPTOMS OF RESPIRATORY DIFFICULTY: any or all of the following

INTERVENTION: Always treat symptoms even if peak flow is not available

• Coughing • Chest tightness • Shortness of breath • Turning blue • Wheezing • Rapid, labored breathing • Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone • Difficulty carrying on a conversation due to difficulty breathing • Difficulty walking due to breathing problems • Shallow, rapid breathing • Blueness (cyanosis) of fingernails and lips • Decreasing or loss of consciousness • Other

Peak flow meter: Yes ___ No ___

Spacer: Yes ___ No ___

CALL 911 IF THE FOLLOWING OCCUR /PERSIST AFTER IMPLEMENTING INTERVENTIONS AS STATED ON THIS HEALTH PLAN

TRIGGERS: (Check those which apply to this student)

- | | | |
|---|--|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Emotions (when upset) | <input type="checkbox"/> cigarette smoke, smog, strong odors (paint markers, perfumes, sprays) |
| <input type="checkbox"/> Colds (viral illness) | <input type="checkbox"/> Irritants: Chalkdust | <input type="checkbox"/> Pollens (trees, grasses, weeds) |
| <input type="checkbox"/> Cold air weather changes | <input type="checkbox"/> Molds | <input type="checkbox"/> Dust and dust mites |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Animal dander – Type: _____ | |

Instructions for Staff:

- Have student stop whatever they are doing
- Send the student to the clinic when experiencing respiratory difficulty as described above

If student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:

Directions for Self-Medication:

____ (initial if applicable). Signatures of the parent/guardian and the physician(see reverse side) indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self medicate.

Field Trips:

- Medications and peak flow meters MUST accompany students on all field trips.
- A copy of this Health Care Plan and current phone numbers MUST be with staff members.
- Teachers MUST be instructed on correct use of asthma medications.

(Emergency contact information and Peak Flow Meter Guidelines on reverse side)

ASTHMA HEALTH CARE PLAN

Parents/Guardian: _____	
Address: _____ Home Phone: _____ Work Phone: _____	
Alternate contacts if parent cannot be reached:	
Name: _____	Name: _____
Home Phone: : _____	Home Phone: _____
Work Phone: : _____	Work Phone: _____
Physician who should be called regarding asthma:	
Name: _____	Phone: _____
	Fax: _____

ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS

GREEN ZONE - Good control >>>>>>>>>>>>>>>>>>>>>>>> <ul style="list-style-type: none"> • No cough or wheeze • Tolerating activity easily • Peak flow above _____ Indicates that student's asthma is under good control. This is where he/she should be every day 	Treatment Plan: 1) Daily School Meds: Circle one: Albuterol / Other: _____ _____ 2) Use before exercise/physical activity: Yes ___ No ___ 3) Other: _____
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YELLOW ZONE - Worsening Asthma >>>>>> <ul style="list-style-type: none"> • Worsening symptoms • More short of breath with activity • Need reliever inhaler more often than usual OR <p>Peak flow between _____ and _____ Indicates a warning that student's asthma may flare unless additional measures are taken.</p>	Treatment Plan: 1) Reliever Inhaler: Circle one: Albuterol/Other: _____ _____ 2) Recheck peak flow 10 minutes after treatment. May return to class if symptoms improve. Vigorous activity should be avoided. May repeat inhaler if no improvement in 20 min: Yes _____ No _____ 3) Call parent to inform of situation. 4) If student is not improving or getting worse, follow Red Zone plan.
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RED ZONE - Danger zone >>>>>>>>>>>> <ul style="list-style-type: none"> • Getting little relief from inhalers OR • Peak flow below _____ • More breathless despite increased medications • Peak flows do not respond to reliever inhaler/nebulizer (include dosage) <p>This is student's danger zone.</p>	Treatment Plan: 1) Call parent to inform of urgent situation. 2) If symptoms continue to be severe and/or parents aren't available call 911 immediately 3) Urgent Medications: _____
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1. As parent/guardian of _____, I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse.
3. This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Physician Signature:		Date:	
Parent Signature:		Date	
School Nurse Signature:		Date:	
Student Signature:		Date:	